

GUIDANCE DOCUMENT

For

*REGULATIONS GOVERNING STANDARDS AND CHARGES FOR
MEDICAL CARE SERVICES TO INDIVIDUALS*

Chapters 200 & 210

November 29, 2002

Approved:

Commissioner of Health

Date

General Comments and Overview

The regulations governing eligibility standards and charges for medical care services to individuals, as approved by the Board of Health, are necessarily somewhat general in nature and cannot be written to cover every circumstance. For this reason, the Commissioner of Health is granted the authority to interpret the regulations so that they are applied consistently to myriad specific circumstances, and to incorporate experience gained in applying the regulations to meet the challenges of delivering health care in an ever changing environment. This Guidance Document provides those interpretations.

Each section of the regulations, e.g. 12VAC5-200-10, is listed in the order in which it appears in the regulations. All the sections are listed, however the amount of material after each section varies considerably. If there is no information, the section is felt to be essentially self-explanatory. Except for the section titles, the Guidance Document generally does not repeat textual material from the regulations.

The Guidance Document is reviewed whenever the regulations are reviewed or when needed. Changes are approved by the Commissioner of Health and are effective upon approval.

Appendices

Appendix 1	Acronyms and Abbreviations
Appendix 2	Sample <i>Self Declaration of No Income</i> letter or statement
Appendix 3	Sample agency support letter or statement
Appendix 4	Sample relative or friend support letter or statement

CHAPTER 200
Regulations Governing Eligibility Standards and Charges for Medical Care Services
to Individuals

Part I
Definitions

12VAC5-200-10. Definitions

College Student

College students are normally considered full pay patients whose charges are not discounted. A district director may choose to discount the charges. If a college student wishes to receive discounted charges, he or she must undergo the same eligibility determination as any other patient and be identified as part of an appropriate family or economic unit. College students who are receiving any support from their family are considered part of the family, and the family's income must be included in determining the student's charges. Such support may take the form of money payments to the student, student expenses paid directly by the parent(s), or in kind support. If the student resides with his or her parent(s) during breaks from class or during vacations, the student is considered to be receiving in kind family support, and the family's income should be included in determining the student's charges.

If a student is married, he or she and his or her spouse are generally considered the family unit, and the spouse's income must be included in determining the student's charges.

If a student can demonstrate that he or she receives no support of any type from his or her family, either financial or in kind, the student may be considered a family or economic unit of one.

Health districts may bill any health insurance plan that provides coverage for the student. College students shall receive non-chargeable services (as defined in the regulations) at no cost. College students who are minors will be treated in accordance with the procedures applicable to minors.

Do Not Contact (DNC)

A DNC patient is a patient receiving family planning, maternity, sexually transmitted infection (STI), or HIV services and who requests that no bills or notices for these services be sent to his or her home. Prior to services being rendered, health department staff shall provide the DNC patient with an explanation of the charges, applicable discounts, and expected payment.

Maternity patients are generally DNC patients only for a limited time, e.g. until it becomes obvious that they are pregnant. A district must determine when to end a maternity patient's DNC status on a case-by-case basis, taking into account relevant factors.

Health districts should make an alternative arrangement whereby DNC patients can be contacted without violating the patient's confidentiality. This will allow health districts to inform patients of needed follow-up services, e.g. for an abnormal Pap smear, and for notifying patients of their unpaid bills. DNC patients' unpaid charges for these services shall not be referred to a collection agency or for debt set-off, and they shall not be denied service.

Family, Family Unit, or Economic Unit

Family Unit The family unit or economic unit (used interchangeably for eligibility purposes) may consist of:

- A. Husband and wife and their minor dependents.
 - B. A single individual and his/her minor dependents.
 - C. An individual with no minor dependents.
1. A woman who is pregnant should be counted as a multiple beneficiary (mother and baby(s) are counted together) when the pregnancy has been verified by a physician or a nurse practitioner working under the supervision of a physician. Alternatively, the pregnancy may be verified by a nurse based on a compatible clinical history and a positive urine or blood pregnancy test. Verification by a nurse becomes effective on the date the nurse makes the determination, but the pregnancy must also be verified by a physician or a nurse practitioner working under the supervision of a physician at the next prenatal visit.
 2. Count all related or non-related persons who share income as an economic unit. "Shared income" is income that is pooled or commingled to support the economic unit. For eligibility purposes the total income from all members of the economic unit should be used to determine the applicant's income level. "Shared expenses" is not the same as "shared income," and does not define an economic unit. Students sharing the rent for an apartment would be an example of shared expenses. Proof of dependency from the Internal Revenue Service is not considered a basis for the determination of a family or economic unit. Examples of separate family or economic units:
 - A. A minor placed in a foster care home and who is the legal responsibility of a welfare agency.
 - B. A minor living with a legal guardian who does not have financial responsibility for the minor.

3. A husband and wife who are separated and are not living together shall be considered separate units. If a husband and wife who are ~~legally~~ separated are living together and sharing their income, the two of them become a single economic unit despite their separated status. (See paragraph 2, above.) *This determination should be made by questioning the client and documenting the client's answer in the client's record.*
4. A Medicaid recipient who is a minor receiving Special Supplemental Income (SSI) payments shall be a separate family unit. A Medicaid recipient without SSI shall be part of a basic family unit as described in paragraph #1. The child who is considered a separate family unit is not part of the larger family unit when calculating their income.
5. For family planning services, individuals requesting DNC may be treated as a separate family unit and may require an eligibility determination. (See Minor, page 13; Family Planning Services, page 23).
6. For joint custody, both parents must designate a head of family. If the head of the family unit is not designated the parent presenting for services will be considered the head of the family. The family unit will be that of the designated head and his/her family unit plus the child in joint custody.
7. The family unit for a parent paying child support excludes the minors for whom the child support payments are intended. The family unit which receives child support payments shall include the minors for whom the child support payments are intended.

Gross Income

Proof of Income. In the majority of cases, income can be verified by determining the family's money wages and salaries before any deductions (gross income). Wage and salary verification must be determined for all adults in the family. (Earned incomes of minor children are excluded.) If there is any question about the authenticity of the pay stub (e.g. no name or social security number), staff may require a statement from the employer on company letterhead. Staff should be sure to determine whether multiple family members are working.

The following documentation can be used as proof of income.

1. Pay stub with year-to-date total. If the calendar year-to-date total is on the stub; and, the applicant was employed by the same employer since January 1st; and, the year-to-date income covers three or more months of continuous employment, then only one pay stub is needed to use the Care Connection for Children (CCC) calendar to compute annual income.

2. If year-to-date totals are not available, then check stubs for the past three consecutive pay periods are recommended.
3. For people who have worked on their current job for less than three months, use current check stubs to determine a regular amount of pay (hourly, weekly, monthly, etc.) and calculate income as if the person were working the entire year.
4. Persons on strike are to be treated as a person who has changed jobs. (Refer to #3)
5. Persons who might be off the payroll for sickness or some other reason should have their family income figured based on the income at the time of application. When they return to work, a new eligibility must be completed.
6. In some cases it may be inappropriate to use check stubs as verification (seasonal workers, for example). In those cases, an income tax form W-2 from the previous year should be requested.
7. When making the initial eligibility application, overtime should be considered part of the gross earnings. If the interviewer notes a large amount of overtime as part of the gross income, the applicant should be asked if the overtime is a regular occurrence. If it is not regular, the applicant can be asked to bring back three future consecutive pay stubs. The eligibility would be recalculated based on the gross pay of those stubs. All pay stubs must note the pay period for which the stated income was earned.
8. If no wage or salary statements are available, then the following verifications are acceptable:
 - A. The most recent annual tax return should be requested. The total income is shown on line 22 of the income tax form 1040. (Line 14 on the 1040A form and line 4 on the 1040 EZ form). If the applicant is self-employed, income is figured as above plus any depreciation shown on line 12 of schedule C. If income includes or is totally from farm income, income must include any depreciation taken on Schedule F (line 16).
 - B. In no tax return is available, one of the following will be considered as adequate proof of income:
 - (1) Statement from employer. Required to be on company letterhead, dated, signed by a company official, and have sufficient information to allow calculation of current gross pay. (In exceptional cases, oral verification from the employer may be used as proof of income.) Although a letterhead statement is preferred in all cases, the district may accept a statement written

on plain paper. If neither of these is available, the district director may accept a self-declaration of income.

(2) Some people who are self-employed may only have ledgers that they keep with their business' revenues and expenses. When these ledgers are brought in as proof-of-income one of two approaches may be used:

(a) If possible, determine what they paid themselves and their family members.

(b) If (a) is not possible then determine their revenues and subtract out all expenses except depreciation. This remaining total will be their gross income.

(3) In certain cases a self-declaration of income is acceptable. Examples are those who are homeless and day workers. Individuals who earn tips can report them in this manner. The applicant should be asked to write out a statement such as "My estimated yearly income is ____." The statement must be signed and dated by the applicant.

(a) Migrant and seasonal workers may also self-declare their income.

(4) A signed letter from the Department of Social Services stating the income used by Social Services to determine eligibility.

9. Social Security and railroad retirement. Any one of the sources listed below may be used as verification:

A. Documents stating the amount of entitlement.

B. Official award letter or notice.

C. Benefit payment check or proof of direct deposit account. Deductions for Medicare Part B are to be added to this amount to compute total monthly income.

D. If none of the above sources are available, other sources, such as an adult child, may be contacted, but only with the written consent of the applicant.

10. Persons Receiving Unemployment Benefits. The only allowable verification is a statement from the Virginia Employment Commission stating the amount of

benefits and the weeks remaining. The person receiving unemployment benefits should be treated as a person who has changed jobs. (Refer to #3.)

11. Worker's Compensation/Veteran's Benefits. (Note: A person receiving these benefits could also be currently employed.) Any one of the sources listed below may be used as verification:

A. Documents stating the amount of the payment.

B. Benefit payment check or proof of direct deposit amount.

12. Applicant states he/she has no income. All applicants claiming no income should be closely questioned about how they are supporting themselves. The interviewer should also make certain that they are identifying the correct family unit.

A. If the applicant states that he/she has no income, the following documentation may be used:

(1) Statement from Virginia Employment Commission denying unemployment compensation.

(2) Termination notice from previous employer.

(3) Layoff notice from previous employer.

B. Applicants who have no income, and none of the documents in 12-A, may "self declare" that they have no income by signing a simple statement to that effect. (See sample statement, Appendix 2.) The statement should list possible sources of income and the declaratory statement should indicate that the applicant has no income from any of those sources.

A self-declaration of income establishes the applicant as a full pay patient.

Upon presentation of a "proof of no income" letter, the applicant will be reclassified as "income A." The applicant has 30 calendar days to obtain a "proof of no income" letter that identifies the source of the applicant's food and shelter. The letter must be from an appropriate institution (e.g. a church or shelter) and must be on the institution's letterhead stationery. (See sample statement, Appendix 3.)

If the applicant is dependent on a relative, friend, or some other non-institutional source of support, the individual providing the source of support must provide the "proof of no income" letter. (See sample

statement, Appendix 4.) The individual must include in the letter a statement of his relationship to the applicant and a certification as to the truthfulness of the letter. The applicant may bring in the relative or friend, along with letter, and have the relative or friend certify its authenticity. (Each district may determine for itself the authentication it will consider acceptable.) Alternatively, the relative or friend may send a notarized letter. As a third alternative, the district director may accept a "proof of no income" letter from the applicant.

If the applicant does not provide a "proof of no income" letter or other income statement within 30 days, the district shall attempt to collect full payment from the applicant. A "proof of no income" letter must be renewed annually.

Applicants seeking confidential family planning, STI, HIV, or maternity services are handled differently. See the definition of a Minor (page 13) and Family Planning Services (page 23).

13. Alimony/Child Support. This can be verified by the applicant providing any legal document (divorce papers, letter of support, judgment, custody papers, copies of checks) that state the amount and frequency of payment. A written declaration of child support is also acceptable. A copy of the ex-spouse's tax return showing alimony payments would also be acceptable.

14. Military Pay. The most recent copy of the military member's Leave and Earnings Statement (LES) form must be used to determine income. Income includes monthly base pay, hazardous duty pay, "bonus pay(s)" and any other special pay(s). Income does not include allowances for subsistence, quarters, or quarters in high cost housing areas.

15. Training Stipends. These are funds paid to a person while in training. This includes Job Corps, or payment of part or all of a salary while in school. Verification can be made by check stub or by a letter of award that the student receives.

16. Child in Foster Care. Children in foster care are considered separate families. Any payment from the Department of Social Services for their care should be considered part of the child's income and not part of the foster parents' income.

17. Family with Income Only from Checking/Savings Accounts. Sometimes an applicant may claim no income, but have a sizable amount of money in a checking or savings account. The district can verify this income by requiring the applicant to bring in a current account statement, passbook, or other document that gives the amount of money in the account. ("Sizable" is a combined amount of more than \$10,000.) When this occurs, the interviewer needs to

determine if the amount is earned income. ("Earned income" is that income that the family was able to save when a family member was employed.)

- A. If the amount is from earned income, only the interest from those accounts should be counted as income.
- B. If the amount is not earned income (examples: money brought into the country by legal aliens, past judgment awards), then the entire amount in the accounts is to be considered as income. It would also be permissible to use the amount that was withdrawn from the accounts in one year's time, but the applicant must have bank records to prove the difference.

18. Other types of benefits.

- A. Private pensions/Military retirement pay. The same types of verifications are acceptable as for the recipient of Social Security. As for most categories, tax records are acceptable.
- B. Regular Insurance or Annuity Payment. See 9A above.
- C. Dividends and Interest. Acceptable types of verification are bank statements (quarterly or semi-annual statements give a better picture of what the annualized amount would be), the past year's 1099 or a copy of the applicant's past year income tax form 1040. Dividends are on line 9; interest is on lines 8a and 8b. For the self-employed and in other cases where the total income is used (line 23 of the form 1040) it is not necessary to add in dividends and interest and other sources of income.
- D. Net Rental Income. Review the relevant tax information. This is generally included in schedule C or E. It will show on line 18 of the income tax form 1040 that is part of line 22.
- E. Net Royalties. Review the relevant tax information. This is generally included in Schedule C or E and will show up as part of line 22 on the income tax form 1040.
- F. Periodic Receipts from Estates or Trusts. Several possible sources of verification are acceptable. These include copies of legal documents, tax records, income tax form 1099 and bank records.
- G. Lump Sum Settlements. These include inheritances, one time insurance payments, and injury compensation awards. Verification can be made by checking the award letter or copying the check. In some cases it may be necessary to check with the court.

H. Net Gambling Winnings. This is shown on line 22 of the income tax form 1040 and is, therefore, part of the line 23 total.

I. Lottery Winnings. Although the recipient should be asked about any income derived from lottery winnings, verification is not required unless the applicant is known to have won a large prize or states they have. "Large" is defined as \$1,000 or more. Lottery winnings should be on the federal tax form.

19. Gross income does not include:

A. Food stamps.

B. WIC checks.

C. Fuel assistance payments.

D. Housing assistance.

E. Money borrowed.

F. Tax refunds.

G. Gifts.

H. Withdrawal of earned income from bank accounts. Interest is to be included as income.

I. Earnings of minor children.

J. Money received from the sale of property.

K. General relief from the Department of Social Services.

L. College or university scholarships, grants, fellowships, assistantships, or any other types of aid that are specified as applicable to tuition; fees; books, supplies, and equipment required or recommended for course work; or housing and food service payments or provided in kind. Assistance that produces income that a student may use without restriction is considered income.

Non-chargeable Services

Non-chargeable services are defined as those services listed in the nonchargeable section 12VAC5-200-150 of these guidelines.

1 Medically Indigent

2
3 Synonymous with Income A.

4
5 Minor

6
7 A minor (as defined in 12VAC5-200-10) will be treated as an economic unit of one when
8 he or she seeks confidential services for a sexually transmitted infection, HIV infection,
9 family planning, or maternity services (including the diagnosis of a possible pregnancy).
10 (These four services may be provided confidentially to a minor without consulting or
11 informing his or her parents.) Minors seeking these confidential services should
12 automatically be treated as income A patients unless the district has reason to believe that
13 the minor, as an economic unit of one, has income that exceeds the income A level.
14

15 †
16
17
18
19

20 **Part II**
21 **General Information**

22
23
24 **12VAC5-200-20.** Authority for regulations
25

26
27 **12VAC5-200-30.** Purpose of chapter
28

29
30 **12VAC5-200-40.** Administration of chapter
31

32
33 **12VAC5-200-50.** Receipts for services
34

35
36 **12VAC5-200-70.** Powers and procedures of chapter not exclusive
37

38
39 **Part III**
40 **Application and Charges**

41
42
43 **12VAC5-200-80.** Application process
44

45 General Procedures
46

1 The eligibility process starts when the Community Health Services (CHS) CHS-1 form is
2 completed.

3
4 If a valid proof-of-income is not presented at the time the CHS-1 is completed, the
5 applicant will receive no discount for the services he or she receives unless he or she
6 provides proof of income within 30 days or at the next visit, whichever is sooner. If a valid
7 proof-of-income is provided within 30 days, charges will be discounted back to the date of
8 completion of the original form CHS-1.

9
10 The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC),
11 CHS, and Care Connection for Children (CCC) require proof-of-income before
12 certification. As necessary, CCC and Child Development Services (CDS) also require
13 proof of the applicant having applied to Medicaid, Supplemental Security Income (SSI), or
14 any other state-sponsored medical insurance program.

15
16 If the applicant does not provide proof-of-income with 30 days, no discounts will be given
17 for prior services. If an applicant provides the information after 30 days and is determined
18 to be medically indigent, the previous charges may be discounted at the district director's
19 discretion.

20
21 When an applicant receives a Medicaid card after the eligibility date, staff are to bill
22 Medicaid for all possible charges. Any credits to the account shall be refunded to the
23 applicant, using the applicant's social security or alien registration number. If the
24 applicant is a minor whose parent, or other adult who is fiscally responsible for the minor's
25 charges, paid the minor's charges, any refund should be issued to the parent or other
26 adult, using the parent's social security or alien registration number.

27
28 When eligibility information is required, the applicant will be charged as a full pay (income
29 F) patient if the applicant does not have valid proof-of-income. These charges may be
30 reduced if the proof-of-income is brought in according to the above guidelines.

31
32 A new eligibility must be completed every 12 months, or as required by a specific
33 program. Eligibility determinations should also be completed when 1) Income scales are
34 revised, 2) The health district has reason to believe the patient's eligibility status or family
35 composition has changed, or 3) When a patient requests a waiver.

36 37 Residence

38
39 Non-mandated services may be limited to residents of Virginia. Proof of residence may
40 be a Virginia driver's license, rent or mortgage payments, utility payments, voter
41 registration, or any other document that establishes Virginia residency. Proof of residence
42 may also be established by meeting the requirements in this Guidance Document under
43 Section 12VAC5-200-10, Gross Income, Proof of Income, 12-B, "no income."

44
45 The district director may limit the provision of non-mandated medical care services based
46 on an assessment of public need and available departmental resources. The district

director may establish policies to limit the provision of non-mandated medical care services provided by the department based on legal residence, e.g. the recipient must be a resident of the health district, or visa status. However, the director may not limit medical care services on a geographic basis if the conditions of the grant or other source funding the medical care services prohibit such a limitation. Mandated medical services may be geographically restricted only to the extent permitted, if any, by state law and regulation and the requirements accompanying federal funds supporting these services. Specific details are provided in the sections on mandated (non-chargeable) services.

12VAC5-200-90. Charges for services

Overview

Services provided by local health districts can be grouped into two broad categories, "clinical care" provided by health district personnel, and "goods" such as laboratory tests, biologicals and pharmaceuticals, and diagnostic tests ordered by district personnel. Clinical care services are charged on a "sliding scale," based on the patient's income. "Goods" are charged on a "flat rate charge" basis, with a provision for local health districts to discount flat rate charges using the sliding scale. (A third category includes services that must be provided at no charge to all patients.)

Establishment and promulgation of charges

The commissioner may designate an individual to maintain and update the tables listing the medical care services charges and codes, and to disseminate updated information to the districts, and other relevant individuals or positions. The commissioner or designee has the authority to determine new charges when there are no appropriate Medicaid or Medicare charges, and establish convenience charges (e.g. charges rounded to the nearest dollar).

Districts may submit requests for new charges (and codes), or for changes in existing charges (and codes), to the commissioner or designee. Districts may not implement new charges (and codes) or change existing charges (and codes), without the prior permission of the commissioner or designee.

Whenever possible, charges for services will use the most appropriate current Medicaid charges (and matching Medicaid codes). If there is no Medicaid charge (or code) for a particular service, the most appropriate current Medicare charge (and code) will be used. If both Medicaid and Medicare charges (and codes) exist for the same service, the Medicaid charge (and code) will be used.

If neither a Medicaid nor a Medicare charge or code exists for a particular service, the commissioner or designee will determine an appropriate charge and code. Estimated or actual costs associated with providing the service, including an administration or handling charge when appropriate, will be determined by one or more districts and submitted to the

1 commissioner or designee. The submission will include sufficient documentation to
2 support the reported costs. The commissioner or designee will review this information
3 and determine a standard charge and code that will apply throughout the state, except
4 that the charge for services in Northern Virginia (as defined in 12VAC5-200-10) may be
5 10% higher than the charge in the rest of the state.

6
7 Charges may include additional charges to cover mileage or other ancillary costs
8 associated with providing a service. For example: If the service is provided away from a
9 health district facility there might be no additional charge for services provided within five
10 miles of the facility; a \$5.00 additional charge for services provided more than five miles
11 but less than 15 miles from a facility; and so forth. (This example is for illustrative
12 purposes only.) The commissioner or designee must approve any such additional
13 charges.

14
15 Any Medicaid or Medicare charges that are higher in Northern Virginia will remain in
16 effect. The commissioner or designee may add additional medical care services to the list
17 of those for which a higher charge is allowed in Northern Virginia.

18
19 The costs of any products (goods) or services which are obtained through a central
20 purchasing contract will be charged to patients at the same rate throughout the state, i.e.
21 higher charges are not permitted in Northern Virginia for these items unless the
22 purchasing contract specifically indicates health districts in Northern Virginia will pay a
23 higher price. Any administration, handling, or other service charges added to these items
24 will be the same throughout the state.

25
26 An underlying assumption of this section is that the majority of services and charges
27 provided by health districts are available through state contracts or other standard
28 arrangements, and therefore the costs are the same to all health districts. Where services
29 and products are only available from local vendors, or for practicable reasons they must
30 be obtained from local vendors, health districts may request that a charge be established
31 that is appropriate to the district's circumstances. In these cases, the district will submit
32 appropriate justification for using a local vendor with their request.

33 34 Sliding scale vs. flat rate charges

35
36 “Sliding scale” charges are determined on the basis of a patient’s income and represent a
37 discount from the “standard” charge, which is usually the Medicaid charge. Income F, or
38 “full pay” patients pay the standard charge. Income B-E patients pay a discounted
39 charge, as detailed elsewhere in 12VAC5-200-10, 12VAC5-200-20, and 12VAC5-200-
40 110, and this Guidance Document. Charges for income A patients are discounted 100%,
41 i.e. they pay nothing.

42
43 “Flat rate” charges represent the cost to the local health district of the goods provided to,
44 or services ordered for the patient, plus, in some cases, an appropriate handling or
45 administration charge. In general, there is no discounting of flat rate charges based on
46 income, and even income A patients pay 100% of the flat rate charge.

District directors have the authority to discount some or all flat rate charges by applying the standard sliding scale discount to them. Sliding scale discounts can be applied to specific goods or services, or categories of goods or services, but not to individual patients. If a given product (goods) or service is discounted, all patients must receive the sliding scale discount for the given product (goods) or service.

If the cost of a flat rate charge item, plus any handling or administration charge, is less than the charge approved by Medicaid, Medicare, or the commissioner or designee, the district may not increase the charge to match that allowed by Medicaid, Medicare, or the commissioner or designee. The district may request the commissioner or designee to be allowed to increase the charge.

"Sliding scale" vs. "flat rate" charges Unless otherwise approved by the commissioner or designee, all charges shall be on a sliding scale basis and there shall be no charge for income A patients. The commissioner or designee must approve flat rate charges prior to implementation. This includes both approval to charge a flat rate charge and the specific charge itself. The commissioner or designee shall determine which charges are subject to a sliding scale and which to a flat rate charge, and shall maintain and promulgate to the districts lists of sliding scale and flat rate charge services along with their appropriate charges. After the commissioner or designee has approved a flat rate charge, the district director may elect to discount the charge in accordance with the standard sliding scale.

There are three categories of charges.

Sliding scale charges In general, all clinical services and procedures provided by health district personnel (physicians, dentists, nurses, nurse's aides, pharmacists, and other health care professionals) shall be charged on a sliding scale basis. Conceptually, these services may be thought of as "hands on" services by a health care provider such as taking a medical history, performing an examination or procedure, or assessing a patient. Included in the basic sliding scale charge for any given service are the cost of any consumable supplies associated with the service such as gloves, examination gowns, necessary examination equipment, and surgical instruments. Patients may not be charged extra for these items.

Flat rate charges In general, flat rate charges apply to goods purchased by local health districts and provided to patients. They also apply to certain services arranged by the health district (i.e. ordered by its health care providers) and provided by others, or in some cases provided by the health district. Flat rate charges generally apply to pharmaceutical and biological products (except those services described in 12VAC5-200-150, "Services provided at no charge to the patient"), laboratory tests, and other tests and diagnostic procedures. Upon approval by the commissioner or designee, flat rate charges may be applied to other goods or services not provided by local health district staff but that are arranged or ordered by them.

Special flat rate charges Local health districts may charge flat rate charges for the following goods and services. Additional goods and services may be added to this list with the approval of the commissioner or designee.

1. Travel medicine services Local health districts may charge flat rate charges for goods and services, including vaccines and their administration (except those described in 12VAC5-200-150, “Services provided at no charge to the patient”), which they provide to a patient who requests medical advice for travel outside the United States. Patients may be charged for the evaluation and recommendations, immunizations, and other goods or services provided to them.
2. Immunizations Local health districts may charge a flat rate charge for immunizations (except those described in 12VAC5-200-150, “Services provided at no charge to the patient”). The intent is to allow local health districts to provide immunizations, especially influenza and pneumococcal vaccines, in a simple expeditious fashion without the need to do eligibility determinations. However, local health districts which provide immunizations this way must also offer an alternative method or venue whereby patients can obtain these immunizations by paying a sliding scale charge (and income A patients will receive these immunizations at no charge). Immunizations provided on a sliding scale basis must be provided with sufficient frequency and convenience that patients have a realistic alternative to obtaining them on a flat fee basis.
3. Other flat rate charges The commissioner or designee may approve and promulgate additional “Special flat rate charges.” The intent is to allow local health districts to charge a flat rate charge for goods or services when it is efficient and beneficial to do so. Typically, these are circumstances where the health district is providing a high volume, low cost service, such as mass immunizations, and the goal is to involve as many people as possible, in as simple and convenient a fashion as possible.

Establishment of charges when health districts partner with other agencies

Charges for clinical services and flat rate charges shall be governed by the Board of Health Regulations (12VAC5-200-10, 12VAC5-200-20, and 12VAC5-200-110), and this Guidance Document. In general, if a health district has primary operational control of a clinic or medical care delivery arrangement, the Board of Health Regulations and this Guidance Document shall determine the charges.

If a health district contracts to provide medical care, on behalf of an outside agency, and the charges or method of determining the charges are specified in the contract, the contract shall govern. If the contract does not specify the charges or how they are determined, the Board of Health Regulations and this Guidance Document shall determine the charges.

For other arrangements, in which the health district contributes only partial support to an operation, other methods of determining patient charges are acceptable. However, health districts cannot charge, or allow patients to be charged, for services that they would normally provide at no or a reduced charge. These include services such as those provided under Section 12VAC5-200-150 (“Services provided at no charge to the patient”) or Title X family planning services. This prohibition applies only if the health district is actually providing these services in partnership with some other agency. It would not apply if the health district does not provide these services in a partnership arrangement. For example, a city operates an indigent medical center with some services provided by the health district. If the health district was not involved in the family planning services provided in the center, the center could determine the charges for this service. If the health district were providing the family planning services, the charges would be determined in accordance with the federal Title X patient charge requirements (assuming the health district was receiving Title X funds).

This section does not restrict a district's ability to bill third party insurance carriers for covered services, unless otherwise prohibited.

12VAC5-200-100. Flat rate charges

See above sections. Additionally, the district director may elect to discount any flat rate charge according to the standard sliding scale. If a district director elects to charge according to a standard sliding scale, an eligibility determination must be done before providing these goods or services. District directors may discount all or only certain flat rate charges. In the latter instance, discounts shall apply to specific items or categories of items (e.g. a specific class of pharmaceuticals) and not to individual patients. If a district director elects to discount flat rate charges, this cannot result in the district operating at a deficit. The commissioner or designee reserves the right to require a district not to discount charges.

12VAC5-200-105. Charges for services provided by contract

12VAC5-200-110. Income levels for charges

12VAC5-200-120. Automatic eligibility

Once it is established that a person is in one of the categories listed below, he or she is eligible for services as a medically indigent person. Once the documentation of one of the categories listed below is provided, no other financial information is necessary for a patient to receive services. However, it is important to obtain any insurance information so that the insurance companies may be billed for services provided.

Documents required for automatic eligibility:

1. General relief: Check stub or letter.
2. Medicaid: Current card or notice of eligibility, the person is listed on the Medicaid printout, or by a documented call to the Audio Response System (ARS) or other automated Medicaid verification systems. A copy of the card shall be made at the time of the eligibility determination or the information on the card may be documented in the applicant's record. Similarly, information obtained from the Medicaid printout or verification system may be documented in the applicant's record. Babies born to mothers on Medicaid do not receive automatic eligibility. Although the applicant may be covered by Medicaid, the remaining family members do not receive automatic eligibility status.
3. School lunch (for school dental services only): The school must verify that the child is eligible for the free lunch program. This eligibility applies only to students eligible for a free lunch and not to students eligible for a reduced lunch.

12VAC5-200-130. Explanation of charges

12VAC5-200-140. Redetermination of eligibility

**Part IV
Nonchargeable Services**

12VAC5-200-150. Services provided at no charge to the patient

General

In accordance with the Code of Virginia (12VAC5-200-150), certain services are to be provided by health districts at no charge to Virginia residents. Because there is no charge, no eligibility determination is required. However health districts may charge patients' private health insurance providers. If the private health insurance provider requires a co-payment, the terms of the provider agreement will probably preclude billing that carrier since the co-payment cannot be collected from the carrier.

Local health directors may limit the provision of nonchargeable services to residents of their local health district. However, in general, services funded by federal grants must be provided to all persons, even those residing outside a particular health district. Local health directors may limit the availability of federally funded services on the basis of residence outside their district. However, they may not completely deny these services to non-district residents.

Nonchargeable services may also be provided at no charge to non-Virginia residents, at the discretion of the local health director. However in general, services funded by federal grants must be provided to all persons, even if they are not Virginia residents. Local health directors may limit the availability of federally funded services on the basis of residence outside Virginia. However, they may not completely deny these services on the basis of residence outside the state.

Nonchargeable services are discussed in detail in the following sections. For reference purposes, the relevant sections of the code are cited here: Immunization of children, § 32.1-46; Examination for suspected tuberculosis, § 32.1-50; Sexually transmitted diseases, § 32.1-57; HIV testing, § 32.1-55.1. However the following sections include diseases and services beyond those that are required in the code and delivery of them or assurance of their availability is required of local health departments.

Immunizations

All immunizations required for children or adolescents by the Code of Virginia must be provided at no charge to the patient for vaccine, vaccine administration, or vaccine handling. Currently, these immunizations include those against diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, Haemophilus influenza type B infection, hepatitis B, and varicella. The Guidance Document allows patients to be charged a flat rate charge for immunizations provided in a Travel Medicine clinic. However, if any of the immunizations required by the Code of Virginia are administered in a Travel Medicine clinic there must be no charge to the traveler as long as the traveler is within the appropriate age group. From time to time additional immunizations will be added to this list and must also be provided at no charge. Consult the Virginia Department of Health, Office of Epidemiology, Division of Immunization for the most current list of required vaccines.

Tetanus, diphtheria, measles, mumps, rubella, and polio (inactivated polio vaccine, IPV) immunizations are to be provided to adults at no cost for the vaccine, even if these individuals obtain these immunizations in a Travel Medicine clinic. The patient may be charged an administration charge but service cannot be denied because of the patient's inability to pay the charge.

All other immunizations provided by the department may be charged to the patient. This includes charging for immunizations administered to children if the immunization is not required by Code of Virginia. Vaccines purchased on federal procurement contracts and provided to the health districts by the Division of Immunization must not be used for a chargeable service. Health districts must use local or coop budget funds to purchase chargeable vaccines.

Tuberculosis

1 State code requires health departments to assess, examine, and test individuals
2 suspected of having, or known to have tuberculosis disease at no charge. This service
3 extends to contacts of individuals with known active tuberculosis as determined by the
4 district director or other appropriate authority, and to individuals with a newly positive
5 tuberculin skin test. (Positivity is defined in accordance with the current Centers for
6 Disease Control and Prevention, American Thoracic Society, American Lung Association,
7 and Agency guidelines.) Individuals assessed, examined, or tested for other purposes,
8 e.g. as an employment-screening requirement, may be charged for this service.

9
10 Assessment, examination, and testing may include initial and follow-up: assessment,
11 physical examination, chest x-rays, tuberculosis skin testing, and sputum collection and
12 testing (collection containers, sputum induction, making and examining a sputum smear,
13 mycobacterial culture and sensitivity, mycobacterial diagnosis by DNA probe, PCR, or
14 other molecular biology techniques). The district director or other appropriate authority
15 shall determine which tests and procedures are appropriate for any given patient.

16
17 Treatment of active disease, or treatment of latent tuberculosis infection (LTBI), may be
18 charged to the patient or the patient's health insurer. The health district should charge a
19 flat rate charge for drugs, laboratory tests (e.g. liver function tests), chest x-rays, and other
20 tests or procedures needed to monitor treatment unless the district director elects to
21 charge for such drugs, tests, x-rays, and other tests or procedures on a sliding scale.
22 Clinic visits shall be charged on a sliding scale. Patients cannot be charged for any
23 services, laboratory tests, or x-rays paid for, directly or indirectly, by the Division of
24 Tuberculosis Control. Health districts may not charge venipuncture, administrative,
25 handling or other fees for services, laboratory tests, or x-rays paid for, directly or indirectly,
26 by the Division of Tuberculosis Control. Health districts may not charge for providing the
27 services of Directly Observed Therapy (DOT) or Directly Observed Preventive Therapy
28 (DOPT).

29
30 Patients with suspected or confirmed tuberculosis (active disease or infection) shall not be
31 denied treatment for non-payment.

32 33 Sexually Transmitted Infections

34
35 Sexually transmitted infections for which there is no charge when seen in a sexually
36 transmitted infections clinic include: presumptive diagnosis and treatment of gonococcal
37 urethritis, cervicitis, pharyngitis, and proctitis; presumptive diagnosis and treatment of
38 chlamydial urethritis, cervicitis, pharyngitis, and proctitis; presumptive diagnosis and
39 treatment of non-gonococcal urethritis and mucopurulent cervicitis; presumptive diagnosis
40 and treatment of pelvic inflammatory disease; diagnosis and treatment of neonatal
41 ophthalmia due to gonococcal or chlamydial infection; diagnosis and treatment of syphilis;
42 clinical diagnosis of genital herpes simplex infection; clinical diagnosis and treatment of
43 chancroid; clinical diagnosis and treatment of lymphogranuloma venereum; clinical
44 diagnosis and treatment of granuloma inguinale; clinical diagnosis of genital human
45 papilloma virus infection; serological diagnosis of hepatitis B virus infection. There is no
46 charge for venipuncture and there are no administrative or handling charges associated

1 with the diagnosis or treatment of the infections identified in this paragraph as being non-
2 chargeable. If any of these diseases (except syphilis, gonorrhea, chancroid, granuloma
3 inguinale, lymphogranuloma venereum) are seen in a setting where the service is billable,
4 the patient should be billed.

5 6 Human Immunodeficiency Virus

7
8 There is no charge for the clinical diagnosis of, or the serological testing for, HIV infection
9 as determined by the presence of anti-HIV antibodies. There is no charge for testing for
10 HIV infection as determined by rapid diagnostic tests for HIV infection that are intended for
11 use and interpretation within a single clinic visit. There is no charge for venipuncture and
12 there are no administrative or handling charges associated with such HIV testing.

13 14 Family Planning Services

15
16 The charges for Family Planning services that are supported in whole or part by federal
17 Title X or Title V funds must be discounted according to the patient's income (as are other
18 medical care services) using the standard sliding scale. This discount also must be
19 applied to Pap smears and other tests obtained as part of the patient's evaluation, and to
20 all contraceptive methods. Patients at income Level A cannot be charged for any
21 services, Pap smears or other tests, or contraceptive products. (Patients who receive Pap
22 smears in clinical settings other than Family Planning, e.g. a sexually transmitted infection
23 clinic, may be charged for their Pap smears.)

24
25 Adult patients requesting confidential family planning services, i.e. those who have
26 requested DNC status, must be treated as an economic unit of one. They may also "self
27 declare" their income if they have no independent income. As a practical matter, women
28 who request DNC status are usually going to be income A if they are entirely dependent
29 on someone else's income and support. Minor patients are handled in a similar fashion.
30 See the definition of Minor, page 13. *College students who are not minors must*
31 *demonstrate that they are not dependent upon their parents before they can qualify for a*
32 *sliding scale discount. See the definition of College Student, page 4.*

33
34 Title X regulations state "clients must not be denied services because of the inability to
35 pay." Therefore patients at income Levels B-F, inclusive, must receive Family Planning
36 services, relevant tests, and contraceptive products even if they fail to pay for them or
37 state that they are unable to pay for them. However, the Title X Family Planning program
38 does expect patients to pay for services, tests, and contraceptive products in accordance
39 with the payment expected of them based on their income. Therefore, patients may be
40 denied Family Planning services, tests, and contraceptive products if they are in income
41 Levels B-F and refuse to pay for them. Moreover, if the patient has made no payments for
42 seven months, the patient has effectively refused to pay, and may be denied subsequent
43 services, tests, and contraceptive products.

Districts are encouraged to work with patients who state that they cannot pay, and make arrangements to accept partial payments until the patient has paid all charges. Alternative payment arrangements are acceptable.

The district director may waive future charges, but may not waive charges accumulated prior to the date that the waiver becomes effective. Virginia Administrative Code, section 12 VAC 5-200-80 requires that district directors may only terminate services when doing so would not be detrimental to the individual's health. Therefore although family planning contraceptive services may be terminated, follow-up services for an abnormal pap smear or other event with ongoing medical implications and consequences may not be denied.

12VAC5-200-160. Immunization services

If a district director elects to provide free immunizations because of an actual or potential outbreak of a communicable disease, the director should document in writing the rationale for such action. No specific format is prescribed, however the document should include: the actual or presumed etiologic agent of the outbreak, the evidence that an outbreak had occurred or might occur, an estimate of the magnitude of the actual or potential outbreak, the number of doses of vaccine provided and their cost, the method of mass immunization, evidence that the immunization program was effective (if available), and a discussion of alternative means (if any) to control the epidemic that did not involve providing free immunizations and a rationale for providing free immunizations. Similar documentation should be created if the commissioner directs a district to provide free immunizations. (Documentation is not required for immunizations that are routinely provided at no cost to specific populations.)

12VAC5-200-170. Other health care services

If a district director elects or is directed to provide free medical care services to a substantial number of citizens as a group, the director should document in writing the rationale or justification for this action. The documentation should include a description of the circumstances or medical problem, the rationale for this action or the direction by the commissioner to do so, the nature and extent of the services provided, the number of individuals served (with a demographic breakdown if available and appropriate), the cost of providing these services, and the outcomes of this action (if these can be determined).

Part V Exceptions

12VAC5-200-180. Exceptions

1 **12VAC5-200-190. Limitations**

4 **12VAC5-200-200. Reserved**

7 **12VAC5-200-210. Charges**

9 See Section 12VAC5-200-90.

12 **Part VI**
13 **Waiver of Charges**

16 **12VAC5-200-220. General**

18 If a district director waives the charges for medical care services, this decision should be
19 documented in writing by the director and placed in the patient's medical record. The
20 documentation should include a statement that all charges are waived for a specific period
21 (which should be specified in the documentation) and a description of the circumstances
22 that necessitate a waiver of the charges. If the waiver is renewed, there should be
23 ongoing documentation of the need for charges to be waived, including a statement that
24 the patient's circumstances have not changed.

27 **12VAC5-200-230. Waivers**

29 In instances where applicants or their immediate families have unusually serious health
30 problems, or an extraordinary financial hardship is demonstrated to exist, and there are no
31 other avenues of care, the patient, guardian, or other authorized person may request a
32 waiver of charges for up to 180 calendar days. A waiver must be requested in writing and
33 approved by the district director.

35 The waiver provides a 100% discount for all medical care services for up to 180 days.
36 The start of the initial waiver period will be the day the waiver request is received by the
37 district. Balances owed prior to the waiver period may not be waived. When a waiver is
38 requested, the health district may complete a new eligibility determination. If the applicant
39 does not provide documentation to support the waiver request or eligibility determination,
40 the applicant must provide it within 10 working days. If the needed documentation is not
41 provided within 10 working days, the beginning date of the waiver will be moved to the
42 date the documentation is provided and the applicant will be responsible for any charges
43 incurred prior to the date of the waiver. The waiver may be extended for periods of up to
44 180 days at the discretion of the district director. The applicant must apply for any waiver
45 extension, and provide the same documentation required for the initial waiver before any

1 extension can be granted. The applicant will be liable for any charges incurred between
2 the expiration of a waiver and the approval of its extension.

3
4 An applicant or the applicant's immediate family will be determined to have unusually
5 serious health problems when the family's total medical bills are $\geq 7.5\%$ of the applicant's
6 family's gross income. Medical bills may include office visits to medical facilities;
7 medications; medical supplies and equipment; dental services; laboratory, radiographic,
8 and other diagnostic tests and procedures; surgery; hospitalization; home health care
9 services; and outpatient treatment. In addition, the applicant may include travel expenses
10 for transporting family members to medical appointments. If family members are
11 transported in a family-owned car, the applicant may claim mileage as an expense at the
12 current state rate for mileage reimbursement. The CCC form 402 may be used to list
13 medical expenses including those that are reimbursed.

14
15 Medical expenses used to determine a waiver in one period may be used in the waiver
16 calculations for subsequent periods. Each time an applicant applies for a waiver, he must
17 present the billings that show his current outstanding indebtedness.

18
19 No waivers will be issued to persons believed to be eligible for Medicaid, Medicare, or any
20 state sponsored medical insurance program for indigent persons until the applicant
21 provides evidence that he or she has applied for them. Health district staff should review
22 the eligibility information already provided or do a new eligibility determination to
23 determine if the applicant may be eligible for one of these programs.

24
25 Extraordinary financial hardship would include such things as natural disasters, damage to
26 or loss of uninsured real or personal property, unpaid legal liabilities, and obligatory and
27 unavoidable expenditures for close relatives outside the family unit.

28 By regulation, the commissioner is designated to grant or deny waivers. The
29 commissioner delegates this authority to district directors. This authority shall not be
30 delegated further down in the organizational structure.

31 32 33 **Part VII** 34 **Appeal Process**

35 36 37 **12VAC5-200-270. Rights**

38
39 A patient who wishes to appeal a decision regarding the delivery of medical care services
40 should generally first appeal to the district director. If the services are provided through a
41 specific program that has its own requirements, e.g. WIC or Breast and Cervical Cancer
42 Screening, the appeal should generally be made to director of the specific program.
43 However in the latter case, district directors should assist patients by providing them with
44 the necessary information to make an appeal, e.g. name and contact information for the
45 program director.

Part VIII
Fraud

12VAC5-200-280. Fraud

In those cases where fraud is suspected, a new eligibility determination should be made and the patient charged accordingly. Previous charges should not be readjusted.

Where there is proof of willful misrepresentation and other agencies may also be misled, those agencies should be notified that the person may be defrauding them. Medical care services may be discontinued to the affected person 30 days after notifying the person in writing, by certified mail, that services will be discontinued.

CHAPTER 210
Charges and Payment Requirements by Income Levels

12VAC5-210-10. Charges and payment requirements except for Northern Virginia

Charges and payment requirements are available for review and copying at all local health departments and at health department headquarters.

12VAC5-210-20. Charges and payment requirements for Northern Virginia

Charges and payment requirements are available for review and copying at all local health departments and at health department headquarters.

APPENDIX 1

Acronyms and Abbreviations

ARS	Audio Response System
CDS	Child Development Services
CHS	Community Health Services
CCC	Care Connection for Children
DNC	Do Not Contact
HIV	Human Immunodeficiency Virus
LES	Leave and Earnings Statement
SSI	Social Security Insurance
STI	Sexually Transmitted Infections (replaces the term STD)
STD	Sexually Transmitted Diseases
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

APPENDIX 2

Sample Individual Statement

SELF DECLARATION OF "NO INCOME"

I, name of applicant, certify that I have no income.

I understand that "income" includes:

- pay, wages, or salaries
- unemployment benefits
- social security benefits
- welfare benefits
- disability, worker's compensation or other payments for an injury or illness
- retirement or pension benefits
- alimony or child support payments
- insurance or annuity payments to me
- interest or dividends from savings accounts or investments
- rental income or other income from a business
- income from royalties, patents, gambling, or lottery winnings

I understand that if I have any of these types of income, I must tell the eligibility worker about them.

I have 30 days to give the health department a letter from a church, shelter, relative, or some other person who is providing my housing and meals. If I do not do this, I will be charged the full amount for any care the health department provides to me.

(Signature of applicant or guardian)

(Printed name of applicant or guardian)

(Date)

APPENDIX 3

Sample Agency Support Statement

STATEMENT MUST BE ON AGENCY LETTERHEAD STATIONERY*

We understand that name of applicant is receiving medical care from the Virginia Department of Health. Because the applicant has no income, our agency is providing food and shelter for the applicant.

(Signature of agency representative)

(Printed name of agency representative)

(Position at the agency)

(Telephone number if not given above)

(Date)

*See page 7, section 8-B-1, of this document for exceptions.

APPENDIX 4

Sample Relative or Friend Support Statement*

I understand that name of applicant is receiving medical care from the Virginia Department of Health. Because the applicant has no income, I am either providing the applicant with food and shelter or providing the applicant with financial support.

Relationship to applicant - for example, friend, cousin

I am providing _____ food and shelter, _____ financial support.

Approximate amount of financial support per month

Signature of person providing support

Printed name of person providing support

Address

Telephone number

Date

*See pages 9-10, section 12-B, paragraph four for details on acceptable authentication of this letter.